PRINTED: 05/31/2011 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			ON	IB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		01	COMPI	
155656		A. BUILDING		05/06/2	2011	
			B. WING	-	1 00/00/2	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CANTEE	DUDY AUTOONO	AND DELIABILITATION OFNITED	I	ORTHGATE BLVD		
CANTER	RBURY NURSING A	AND REHABILITATION CENTER	FORT	WAYNE, IN46835		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
K0000						
			1			1
	A Life Safety Co	ode Recertification and	K0000	Submission of this Plan of		
	State Licensure	Survey was conducted by		Correction does not constitu		
		e Department of Health in		admission by this facility of a	h in the	
		1 42 CFR 483.70(a).		fact or conclusion set forth in		
	decordance with	142 C1 K 403.70(u).	statement of deficiency. The plan of correction is being submitted as required by late respectfully request this play correction as our allegation.		15	
	G D.4 0	5/07/11			v. We	
	Survey Date: 0:	5/06/11				
					of	
	Facility Number	r: 000275		compliance.		
	Provider Number	er: 155656				
	AIM Number:	100290930				
	Surveyor: Mark	c Caraher, Life Safety				
	Code Specialist					
	Code Specialist					
	A. d. T.C.C.C.					
		ety Code survey,				
	1	sing and Rehabilitation				
	Center was foun	nd not in compliance with				
	Requirements for	or Participation in				
	Medicare/Medic	caid, 42 CFR Subpart				
		Safety from Fire and the				
	` ''	the National Fire				
		ciation (NFPA) 101, Life				
	` `	SC), Chapter 19, Existing				
		cupancies and 410 IAC				
	16.2.					
	This one story fa	acility with an attached				
	two story Assist	ed Living wing was				
	1	e of Type V (000)				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2TVX21

Facility ID:

000275

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED D. WING 05/06/2011			ETED		
		155656	B. WING	_		05/06/2	U11
NAME OF PROVIDER OR SUPPLIER					DRTHGATE BLVD		
_		ND REHABILITATION CENTER			/AYNE, IN46835		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
K0034 SS=E	areas not separate Battery operated resident rooms. Capacity of 120 at the time of this volume o	ed from the corridor. smoke detection is in all The facility has a nd had a census of 112 at isit. Robert Booher, REHS, Life ist-Medical Surveyor on found not in compliance ntioned regulatory evidenced by the okeproof towers used as ance with 7.2. 19.2.2.3, ation and interview, the ensure 1 of 2 stairway were in accordance with in 7.2.1.5.4 requires a tening device to be efficient practice affects the vicinity of the 500 Hall first floor	K0	034	It is the practice of this facility ensure that stairways and sm proof towers used as exits ar accordance with state regulations. (1) Corrective at taken for alleged deficient practice: AL stairwell door repaired to latch into the doo frame and is equipped with a latching mechanism. (2)Identification of other area potentially affected by alleged deficient practice: Doors throughout building have been assessed to ensure that they latch into door frame and are equipped with latching	noke re in ction r s d	06/06/2011
	Maintenance Assistant during a tour of the				equipped with latching mechanism. (3)Measures in	place	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	JLTIPLE CON		(X3) DATE S		
AND PLAN	OF CORRECTION		A. BUII	LDING	01	COMPL	
		155656	B. WIN			05/06/20	JII
NAME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER				2827 NC	DDRESS, CITY, STATE, ZIP CODE ORTHGATE BLVD /AYNE, IN46835		
(X4) ID				ID			(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	COMPLETION DATE
K0038	05/06/11, the Ass first floor stairwe the door frame ar a latching mecha interview at the t Maintenance Ass residents in the fa enter the Assisted facility and acknow first floor stairwe with a latching m 3.1-19(b)	ime of observation, the distant stated Health Care acility are allowed to deliving portion of the owledged the 500 Hall cell door was not provided nechanism.			to ensure that alleged deficie practice does not recur: Maintenance director will con routine checks during maintenance rounds to ensure that doors are latching as required. Any doors found to issues will be addressed and corrected. (4) How measures be monitored to ensure that alleged deficient practice does not recur: Maintenance Direct will document door checks or maintenance round log and we report to administrator any isset that are identified. Administrativill review doors for latching correctly during wkly rounds a will discuss findings with maintenance director as need Maintenance rounds Log will reviewed monthly by the CQI committee for 3 months and then once a quarter thereafted.	have have swill es tor n vill sues ator and ded. be	
SS=E	with section 7.1. Based on observation facility failed to earess through 5 accessible for residiagnosis requiremeasures. LSC 1 within a required not be equipped a requires the use of	at all times in accordance 19.2.1 ation and interview, the censure the means of of 7 exits were readily sidents without a clinical ang specialized security 19.2.2.2.4 requires doors ameans of egress shall with a latch or lock that of a tool or key from the ception No. 1 requires	K	0038	It is the practice of this facility ensure that exit access is arranged so that exits are reaccessible at all times in accordance with state regulations. (1) Corrective act to correct alleged deficient practice: Access code has be posted at doors that are equi with a key pad. (2) Identificat of other potential areas that it potential to be affected by alledeficient practice: Maintenar	een pped ion nave eged	06/06/2011

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2TVX21 Facility ID:

000275

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND FLAN	OF CORRECTION	155656	1	LDING	01	05/06/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	ORTHGATE BLVD		
		ND REHABILITATION CENTER			VAYNE, IN46835		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
TAG	door locking arradelayed egress sheare occupancies of the residents rescurity measure provided that stadoors at all times affects residents needing to exit the Front Entrance, 1	ff can readily unlock such s. This deficient practice , staff and visitors ne building from the 100 Hall Foyer, 400 Hall and the 500 Hall exit.		TAG	Director conducted facility routo identify doors with key pactused for access. (3) Measure place to ensure that alleged deficient practice does not remaintenance Director will examine doors during routine maintenance rounds to ensure that codes are posted and accessible. (4) How corrective measures will be monitored: Maintenance Director will document rounds on maintenance log. Administrative will be review wkly. Maintenation will be discussed at CQI monthly for 3 months and the quarterly, thereafter.	unds I es in cur: e re ator ance	DATE
	facility from 12:2 05/06/11, the Fro Foyer, 400 Hall e 500 Hall exit doo locked and could four digit code, b posted. Based or Administrator du at 2:20 p.m. on 0 the 300 Hall hav be in a secure bu without the clinic portions of the fa	sistant during a tour of the 20 p.m. to 2:20 p.m. on ont Entrance, 100 Hall exit, Rehab exit and the ors were magnetically be opened by entering a out the code was not in interview with the uring the exit conference 5/06/11, only residents in the a clinical diagnosis to ilding and a resident call diagnosis in the other recility would have to ask to let them out if they did			quarterly, thereafter.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTI		IDENTIFICATION NUMBER:	A. BUILDING 01		COMPL	COMPLETED	
		155656	B. WING			05/06/2	011
NAME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER			•	STREET A 2827 NO	DDRESS, CITY, STATE, ZIP CODE ORTHGATE BLVD VAYNE, IN46835		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
K0050 SS=F	varying conditions shift. The staff is to is aware that drills routine. Responsice conducting drills is competent person exercise leadershice conducted between announcement manualible alarms. Based on recordifacility failed to conducted quarter and third shift for deficient practice the facility includivisitors. Findings include Based on review Fire/Evacuation with the Administ Maintenance Assistantes and third shift in the third on interview at the Administrator conducted in the conducted in the shift in the difference of the shift in the third on interview at the Administrator conducted in the conducted in	s who are qualified to p. Where drills are in 9 PM and 6 AM a coded by be used instead of 19.7.1.2 review and interview, the ensure fire drills were early on the first, second in 1 of 4 quarters. This is affects all occupants in ding residents, staff and in the companion of the	Ko	050	It is the practice of this facility hold fire drills as required by regulations. (1) Corrective Ac Fire drills have been conduct as required by state guideline and are current. (2) Identifica Monthly documentation recoir reviewed and found to be cur with required documentation. Measures taken to ensure the alleged deficient practice does not recur: Maintenance Direct will maintain a binder in addit to the facility's TELS program will have all fire drill informati available. (4) Monitor of system Maintenance director will promonthly fire drill documentati the administrator who will rever for compliance. Fire drill reper will be discussed in the CQI committee monthly for 3 morand the quarterly thereafter. It trends of non-compliance will addressed and corrected.	state ction: red es ation: rds rrent (3) at es ctor tion n that on em: vide on to riew orts aths Any	06/06/2011

NAME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PELL TAG (MITTER BLVD) OF third quarter fire drills available for review. 3.1-19(b) K0069 Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen exhaust system baffles was installed correctly. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 3-2.5 states filters shall be installed at an angle not less than 45 degrees from the horizontal. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 12:20 p.m. to 2:20 p.m. on 05/06/11, five of five baffles in the kitchen range hood exhaust system. Based on interview at the ensure that alleged deficient practice does not recur. A preventative maintenance Director will inservice staff on proper installation. (4) Monitoring system to ensure that alleged deficient practice does not recur. Maintenance Director will inservice staff on proper installation. (4) Monitoring system to ensure that alleged deficient practice does not recur. Maintenance Director will inservice staff on proper installation. (4) Monitoring system to ensure that alleged deficient practice does not recur. Maintenance Director will inservice staff on proper installation. (4) Monitoring system to ensure that alleged deficient practic	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155656		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/06/2011	
REGULATORY OF LSC IDENTIFYING INFORMATION TAG				STREET A 2827 No	ORTHGATE BLVD	
R0069 SS=E K0069 SS=E Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen exhaust system baffles was installed correctly. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 3-2.5 states filters shall be installed at an angle not less than 45 degrees from the horizontal. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 12:20 p.m. to 2:20 p.m. on 05/06/11, five of five baffles in the kitchen range hood are aligned horizontally in the kitchen range hood exhaust system. Based on interview at the	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
time of observation, the Maintenance Assistant acknowledged five baffles in the Assistant acknowledged five baffles in the log will be reviewed by the CQI		Cooking facilities a with 9.2.3. 19.3. Based on observations facility failed to exhaust system be correctly. NFPA Standard for Ven Protection of Corrections, 3-2.5 installed at an and degrees from the deficient practice resident, staff or the kitchen. Findings include: Based on observations include: Based on obser	are protected in accordance 2.2.6, NFPA 96 ation and interview, the ensure 1 of 1 kitchen saffles was installed 96, 1998 Edition, tilation Control and Fire mmercial Cooking 5 states filters shall be gle not less than 45 horizontal. This e could affect any visitor in the vicinity of :: ation with the sistant during a tour of the 20 p.m. to 2:20 p.m. on five baffles in the od are aligned as kitchen range hood Based on interview at the on, the Maintenance	K0069	ensure that cooking facilities protected within facility guidelines. (1) Corrective ac Current baffles have been replaced with new ones that aligned vertically verses horizontally. (2) Identification other potential areas that coube affected by alleged deficie practice: Facility rounds indithere is no other equipment requires use of baffles on premises. (3) System change ensure alleged deficient practices not recur: A preventati maintenance program in place check baffles wkly after clear to ensure they are appropriatinstalled. Maintenance Direct will inservice staff on proper installation. (4) Monitoring systo ensure that alleged deficient practice does not recur: Maintenance Director will chebaffles during routine dietary rounds and will document findings. Administrator will rupm log on wkly basis to ensuce compliance. Results of the Fereign of the first process of the first p	are are are a of uld ent icated that e to ctice ve ce to nings tely ctor /stem ent eck eview ure PM

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/06/2011	
NAME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER			2827 N	ADDRESS, CITY, STATE, ZIP CODE ORTHGATE BLVD VAYNE, IN46835	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	kitchen range exhorizontally. 3.1-19(b)	naust hood are aligned		committee on a monthly basi 3 months and then one mont quarter thereafter. Any non-compliance identified will addressed as needed throug re-education.	h a Il be
K0144 SS=F	exercised under lomonth in accordant 3.4.4.1. Based on record facility failed to opercentage for the the generator for 3-4.4.1.1 of NFP testing of general emergency electraccordance with 6-4.2 of NFPA 11 in Level 1 and Leexercised at least minimum of 30 r following method a. Under operating or at not less than (Emergency Powrating. b. Loading that nexhaust gas temp recommended by The date and times.	review and interview, the document the load e monthly load test for 3 of 12 months. Chapter A 99 requires monthly tors serving the ical system to be in NFPA 110. Chapter 10 requires generator sets evel 2 service to be once monthly, for a minutes, using one of the ds: ag temperature conditions in 30 percent of the EPS eer Supply) nameplate	K0144	It is the practice of this facility ensure that generators are inspected wkly and exercised under load for 30 minutes in accordance with state regulations. (1) Corrective Act for alleged deficient practice: Generator load test have been an wkly as required and documentation shows load capacity running at 40%. (2) Identification of other potential areas to be affected by alleged deficient practice: Facility rous completed by Maintenance Director did not find any othe equipment that is affected. (3) System change to ensure the alleged deficient practice does not recur: Maintenance staff inserviced on proper way to be load capacity of generator who will be deficient practice does not recure that alleged deficient practice deficient practice deficient practice deficient practice deficient pr	en al ed unds er s) at es was figure nen ring ged ecur:

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Event ID:

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000275

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 05/06/2011	
CANTER	NAME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER			ADDRESS, CITY, STATE, ZIP CODE ORTHGATE BLVD WAYNE, IN46835	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	based on facility deficient practice residents, staff and Findings include Based on review Generator" documents documents. The staff of the staff o	operations. This e could affect all and visitors. of "Direct Supply TELS mentation with the sistant from 10:45 a.m. to 6/06/11, monthly sting documented on 11 and 04/25/11 show the rator ran for at least thirty ach documented load test a exhaust gas temperature 1 and the percentage of 02/28/11 and 04/25/11 p% and "FULL" for on interview at the time 1, the Maintenance 1 the facility did not recentage of load capacity ated load test dates and the percent of load capacity ated load test dates and the percent of load capacity ated load test dates and the percent of load capacity ated load test dates and the percent of load capacity ated load test dates and the percent of load capacity ated load test dates and the percent of load capacity ated load test dates and the percent of load capacity ated load test dates and the percent of load capacity ated load test dates and the percent of load capacity ated load test dates and the percent of load capacity ated load test dates and the percent of load capacity ated load test dates and the percent of load capacity ated load test dates and the percent of load capacity at the load test dates and the percent of load capacity at the load test dates and the percent of load capacity at the load test dates and the percent of load capacity at the load test dates and the percent of load capacity at the load test dates and the percent of load capacity at the load test dates and the percent of load capacity at the load test dates and the percent of load capacity at the load test dates and the percent of load capacity at the load test dates and the percent of load test dates and the load test dates and the	1	CROSS-REFERENCED TO THE APPROPRIAT	DATE DATE J ance. 3 rter